



Commonwealth Indemnity Plan Statement of Verification for Student Coverage Application

Under the GIC's family plan, insurance coverage for a dependent ends the last day of the month in which he/she turns age 19. To ensure continuity of coverage, you must complete in full a "Statement of Verification for Student Coverage" prior to the dependent's 19th birthday. If you would like to apply for student coverage on behalf of your child, please complete the Statement of Verification for Student Coverage" for the family plan under which you have health insurance. If you are not enrolled in any health insurance plan through the GIC, but have the GIC Dental/Vision plan for managers, legislators, legislative staff and certain executive office staff, call the GIC at 1.617.727.2310 for the GIC Dental/Vision student form. Please keep in mind the following:

- Students who attend school less than full time are not eligible for student coverage.
- The insured must be enrolled in family plan coverage.
- The insured must fill out the top section of the form and forward it to the educational institution to complete section two and return it to the address listed on the form.

Important Information

Upon receipt of your application, UNICARE, the administrator of the Commonwealth Indemnity Plan, will determine student coverage eligibility and effective dates. Once this application has been approved, the Plan will contact you every six months to reverify the full-time student status of your dependent student. If you do not respond to these requests for reverification, your student-dependent's coverage will be terminated.

It is your responsibility to notify either the Group Insurance Commission or UNICARE when your student dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school, gets married, or graduates. Health insurance coverage for your student-dependent (age 19 and over) ends at the end of the month in which your child ceases to be a full-time student. Student coverage for a dependent on a school-approved medical leave of absence ends on the last day of the semester in which he or she last attended class, at which time he or she may apply for Dependent COBRA coverage. Your dependent's options to continue coverage if any of these events occur will be provided to you with every student reverification you receive from your health plan. You may also receive information concerning these options by calling UNICARE's Commonwealth Service Center at 1.800.442.9300.

The Plan can only accept original applications, not photocopies or fax transmittals.

We suggest you keep a copy of this application for your records.

For additional information about student coverage, see the
GIC's website: www.mass.gov/gic



Commonwealth Indemnity Plan STATEMENT OF VERIFICATION - STUDENT COVERAGE I. (COMPLETED BY INSURED)

PLEASE PRINT AND ANSWER ALL QUESTIONS, forwarding this to the educational institution to complete the second section and return to the Commonwealth Service Center. Be sure to refer to important information on page one of this application.

Name of Insured _____ Insured's Social Security # _____
Address _____ Telephone Number (____) _____

Place of Employment _____

Name of Student _____ Student's Social Security # _____

Relationship to Insured _____ Student's Date of Birth ____/____/____

Name of Educational Institution Student is Attending _____

Address of School _____

City, State, Zip _____

Has your dependent's education been interrupted for more than 24 months from his/her 19th birthday? Yes___ No___

I understand that I must notify UNICARE's Commonwealth Service Center when my dependent is no longer a full-time student, withdraws from school, is put on a medical leave of absence from school or graduates; and I understand that my health plan may, at times, certify with the educational institution my dependent is attending that he/she is enrolled full-time. I have read the important information section on page one of this form.

Signature of Insured _____ Date _____

II. EDUCATION CERTIFICATE (COMPLETED BY INSTITUTION)

The above student has been accepted or is currently enrolled in our educational institution.

Date Admitted: _____ Expected date of graduation: Month _____ Year _____

a. Full-time _____ If full-time has he/she been considered full-time since admission? ___ yes ___ no
If no, other than for a medical leave, when was he/she not considered full-time? _____

b. Part-time _____ c. Minimum full-time credit hours _____

d. Is the student on a medical leave of absence? Yes _____ No _____ If yes, leave approved From _____ To _____

Name of Educational Institution

Name of Registrar
PLEASE AFFIX SCHOOL SEAL

Date

Signature of Registrar or Designee

Return application to:
UNICARE, Commonwealth Service Center
PO Box 9016
Andover, MA 01810-0916

III. FOR PLAN USE ONLY

Approved _____ Effective Date ____/____/____ Expiration Date ____/____/____

Denied _____ Reason _____

Reviewed by _____ Date ____/____/____